STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121519-001**

Celtic Insurance Company, Inc.
Respondent

Issued and entered
this 4TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 19, 2011, XXXXX on behalf of his wife XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health benefits under a group medical health insurance policy underwritten by Celtic Insurance Company, Inc. The Commissioner notified Celtic of the external review and requested the information used to make its adverse determination. The Commissioner received Celtic's response on May 25, 2011. On May 27, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The case involves medical issues so the Commissioner assigned it to an independent review organization, which provided its analysis and recommendation to the Commissioner on June 10, 2011.

II. FACTUAL BACKGROUND

On Thursday, September 2, 2010, Petitioner went to an urgent care center near her home. She had a variety of symptoms: extreme difficulty walking and maintaining her balance; numbness in both feet; and pain in the right arm, neck and right midsection of her body. The urgent care staff advised her to seek treatment at an emergency room.

Petitioner's husband took her to XXXXX Hospital. The hospital is a member of Celtic's provider network. The treating physician ordered a CT scan, an MRI, lumbar puncture, heart monitoring, and blood tests to check the Petitioner for possible neurological problems, spinal tumor, Lyme disease, and multiple sclerosis. The Petitioner was admitted to the hospital and underwent a 24-hour steroid treatment to restore feeling to her feet, arms and legs.

The test results were received over the next several days (over the Labor Day weekend). The Petitioner was discharged on Tuesday, September 7, with a diagnosis of multiple sclerosis.

Celtic denied coverage for the treatment the Petitioner received at XXXXX Hospital, ruling that the hospitalization was not medically necessary because the treatment she received could have been provided on an outpatient basis. The Petitioner appealed the denial through Celtic's internal grievance process. Celtic issued its final adverse determination affirming its denial of coverage on March 16, 2011.

III. ISSUE

Did Celtic correctly deny coverage for the Petitioner's September 2-7, 2010, hospitalization?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination of March 16, 2011, Celtic stated that it had sent the Petitioner's medical records to an outside medical review organization. Celtic based its claim denial on that report, which contained the following analysis:

> The medical reviewer determined that the inpatient admission from 9/2/10 through 9/7/10 was not medically necessary. [Petitioner] presented with lower extremity weakness. A diagnosis could have been established without the need for acute hospitalization, such as in the emergency department or while under 23 hour observation. The diagnosis is made utilizing a lumbar puncture and MRI findings. Once a diagnosis of multiple sclerosis was established, [Petitioner] could have been discharged as she was ambulatory and did not require any medical, cardiac or neurological monitoring. Intravenous Solu-Medrol [*sic*] does not require acute

> inpatient hospitalization and can be provided in a non-acute hospital setting, such as an infusion center. The inpatient hospitalization was therefore not medically necessary as once a diagnosis is established, outpatient treatment was appropriate.

Petitioner's Argument

The Petitioner is appealing Celtic's denial of coverage based on "Celtic Insurance's contention . . . that a diagnosis could have been established without the need for acute hospitalization" and its claim that once a diagnosis was established [Petitioner] could have been discharged as she was ambulatory, noting:

> Celtic used the test results MRI, CT, Lumbar puncture performed in the ER to deny all benefits including the ER visit and tests. However, the results of the tests (including Mayo Clinic evaluation) were not established until 9-3. Celtic denied the claim based on test findings rather than the admitting work-up to deny benefits for services provided on 9-2 (including the MRI, CT and lumbar puncture). In addition, with Celtic being closed for the holiday, Celtic could not advise XXXXX of "no benefits" until 9-6 after which the hospital services had already been provided.
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> Our contention is that if Celtic is using the ER visit and all tests (MRI, CT and Lumbar puncture) done in the ER to determine that the illness was MS (as opposed to a spinal tumor, brain tumor, paraplegia, etc.) the services should be covered. Celtic is using information obtained "after the fact" to deny these claims and refuses to pay for testing services they "used" to make their denial. . . .

Commissioner's Review

The course of Petitioner's treatment at XXXXX Hospital is documented in records prepared by hospital physicians for the period September 2 through September 7. Her initial examination by Dr. XXXXX reported the reason for admission as, "acute onset paraplegia" and the chief complaint as "difficulty walking."

Medical events relevant to this review, obtained from the medical records submitted by the parties, are recounted below:

DATE	TIME	EVENT
Thursday 9/2	7:00 pm	Petitioner arrives at XXXXX emergency room. Examined by Dr. XXXXX. Tests ordered. CT scan of head, results negative. Dr. XXXXX thought Petitioner might have a neurological disorder. Referred to Dr. XXXXX (neurology consultation).

	10:30 pm	MRI of brain and cervical spine. MRI of thoracic spine. Dr. XXXXX indicated that she would await the MRI results to determine if lesions were present which might indicate presence of MS.
Friday 9/3		Petitioner admitted to XXXXX after MRI results received. Placed on IV Solu-Medrol.
	9:30 am	Occupational therapy evaluation.
	10:00 am	MRI report prepared.
Tuesday 9/7	10:00 am	Petitioner discharged.

Celtic has not disputed that the Petitioner was in need of emergency medical attention when she arrived at the hospital on the evening of September 2. In its final adverse determination, Celtic even suggested that the emergency department was an appropriate place for her condition to be diagnosed. Further, Celtic did not question the medical necessity of any of the tests ordered by the treating physicians. Nevertheless, Celtic denied coverage for the emergency room treatment and the medical tests.

The Celtic policy provides coverage for emergency care and medical tests. Celtic has not offered an explanation for its denial of coverage for this care. Because Celtic did not question the medical need for the emergency department care and the medical tests ordered while the Petitioner was in the emergency department, the Commissioner reverses the denial of coverage for those items.

The remaining issue concerns Celtic's denial of coverage for the hospital expenses incurred from the time of Petitioner's admission to the time of her discharge.

In its final adverse determination, Celtic wrote, "Once a diagnosis of multiple sclerosis was established, [Petitioner] could have been discharged as she was ambulatory and did not require any medical, cardiac or neurological monitoring." Celtic has not indicated when the Petitioner's diagnosis was established. There is no indication in the submitted medical records that the Petitioner was diagnosed with multiple sclerosis before her discharge on September 7. Her physicians speculated that multiple sclerosis might be the cause of her symptoms but the diagnosis was not made until the tests were complete and the results reported. Various test results were reported during the Petitioner's hospital stay but no single report established the diagnosis. The first document that reported a diagnosis was the September 7 discharge summary of Dr. XXXXX. (The discharge summary lists both the admission diagnosis and the discharge

diagnosis as multiple sclerosis. However, the admission diagnosis was not definitive since the doctors treating the Petitioner at the time of her admission were considering several other diagnoses including Lyme disease, injury, and a tick bite to explain the Petitioner's symptoms.)

Celtic has denied coverage for all of Petitioner's treatment based solely on the fact that the IV therapy she received after her admission could have been provided on an outpatient basis. The Office of Financial and Insurance Regulation's own medical reviewer concurred that the intravenous Solu-Medrol could have been administered through a visiting nurse service. The IRO went further and stated that both the IV and the Petitioner's medical tests could have been performed on an outpatient basis.

Citing only its belief that the IV treatment could have been provided as an outpatient service, Celtic denied coverage for *all* of Petitioner's care. Celtic's ruling leaves unanswered the question of how the IV care was connected to the care provided before the IV treatment began. Similarly, the IRO provided no analysis of the initial emergency care or subsequent lab tests but simply asserted that, because hospitalization was not necessary, all the Petitioner's treatment should be denied coverage.

The Commissioner rejects the coverage decision of Celtic and the recommendations of the IRO.

The Petitioner sought emergency room care for a legitimate medical emergency (she was suddenly dizzy and unable to walk). When she was evaluated in the hospital emergency department, the physician was unable to diagnose her problem and requested examination by a specialist. The specialist ordered a series of tests which were appropriate given the Petitioner's symptoms. (Neither Celtic nor the IRO questioned the medical necessity of the tests.)

The IRO cited three reasons why the Petitioner did not need to be treated at the in-patient level of care: 1) her intravenous medication could have been provided through a visiting nurse service; 2) the Petitioner was "fully independent in her ambulation skills" (when she became ambulatory is not specified); and 3) the laboratory tests could have been provided on an outpatient basis.

However, these findings do not resolve the issue of Celtic's obligation to provide coverage for the Petitioner's hospitalization. The Celtic policy devotes four pages to what is characterized as "The Health Care Certification Program." (Policy, Section III, pages 24-28.) The program requires certification for hospital confinements, including confinement resulting from a medical emergency. In the case of a medical emergency, however, it is not required that certification be obtained before services are rendered or expenses are incurred. (Normally, under the policy, notification of hospital confinement must occur two weeks before scheduled confinement.) The notification of an emergency hospital confinement "must take place by the

next business day following the first day of hospital confinement." (Policy, page 25.) The Commissioner notes that the Petitioner's husband was in contact with Celtic even before admission. The policy's notification requirement, therefore, was satisfied.

The certification program permits Celtic to require additional medical information be submitted before coverage is approved. The program also permits Celtic to require that selected medical procedures be performed at an ambulatory-care facility or doctor's office as an alternative to hospitalization. However, the policy (page 26) states that these requirements do not apply to a hospital confinement as the result of a medical emergency.

Nothing in the policy, however, prohibits Celtic from conducting a concurrent review of Petitioner's hospitalization. Celtic was promptly informed of the Petitioner's arrival at XXXXX Hospital but did not attempt to review or guide her treatment. The records submitted by Celtic for this review do not show that Celtic made any attempt to communicate with the Petitioner, her husband, or the hospital during Petitioner's hospital admission. The only reported contacts with Celtic were three telephone conversations, initiated by the Petitioner's husband, at which time he was informed by Celtic that he was proceeding correctly. (Letter from XXXXX to Celtic dated February 21, 2011.)

Because Celtic was timely notified of the Petitioner's hospitalization and because Celtic elected not to challenge her admission or offer alternatives to hospitalization, the Commissioner finds that Celtic effectively waived its prerogatives under its Health Care Certification Program.

The Commissioner finds that the Petitioner's emergency room treatment on September 2, 2010, and subsequent hospitalization of September 2 through September 7, 2010, all of which preceded Petitioner's final diagnosis, were covered benefits under the policy.

V. ORDER

The Commissioner reverses Celtic Insurance Company, Inc.'s, March 16, 2011, final adverse determination. Celtic shall provide coverage for Petitioner's September 2, 2010 to September 7, 2010, hospitalization services (emergency and inpatient) subject to any applicable copayments or deductibles. Coverage shall be provided within 60 days of the date of this Order and Celtic shall, within seven (7) days of providing coverage, submit to the Commissioner proof it has implemented this Order.

If necessary to enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.